DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/27/09 and completed on 07/29/09, the sample included 2 residents for complete review, 9 residents for focus review, and 1 closed record for review. The sample included 2 supplemental residents to verify specific concerns.	F 000	General Disclaimer Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of policies/ procedures, and staff interview, the facility failed to implement their written policies and procedures for contacting the North Dakota Department of Health Certified Nurse Aide (CNA) registry for 3 of 3 CNAs (#3, #4, and #5) hired in the last four months. Findings include: Review of the facility policy, titled "Registry/ Licensure Verification" occurred on 07/29/09. This policy, revised in January, 2008, stated, "The Good Samaritan Society will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property. It is the policy of The Evangelical Lutheran Good	F 226	1. Human Resources Coordinator will provide proof of Registry/Licensure verifications for employees #3, #4, and #5. HR coordinator received education from the DNS on the policy and procedure of CNA Registry/Licensure verification on 8/17/2009.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Bowersox, CNHA | TITLE: Administrator | (X6) DATE: 8/26/2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 1 Samaritan Society to contact the applicable registry on all employees regardless of positions. . . ." On 07/29/09 at 10:00 a.m., review of five employee files revealed the facility failed to check the CNA registry prior to employeeing one CNA (#3), hired 07/07/09. The surveyor expanded the sample to include two other CNAs (#4 and #5) and found the facilipx adomed to check the CNA registry prior to allowing these two employees to work directly with residents. The Administrator (#6), during interview on 07/29/09 at 11:50 a.m., indicated the registry should be checked prior to allowing CNAs to work on the floor with residents.	F 226	2. All residents have the potential to be affected. 3. Human Resources coordinator will perform Registry/Licensure verification checks utilizing the ND Department of Health and Services web site to check on all new employees prior to any direct care contact with residents to ensure all CNA's have an active certification. A copy of the verification will be printed and placed in the employee personnel folder as evidence of the registry verification check. Human Resource Coordinator will utilize a check off sheet for all new CNA hires to ensure compliance in this area. 4. Human Resources Coordinator will audit all new CNA personnel files for verification of CNA certification. The audit will be completed for 3 months. A copy of the audit results will be provided to the QA/CQI committee for further recommendations.	09/11/2009
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of policy and procedure, and staff interview, the facility staff failed to ensure 1 of 6 sampled residents (Resident #1) identified by the facility as having chewing or swallowing problems, received the care and services necessary regarding a swallowing evaluation and care planning of interventions implemented for the swallowing problem. Failure to provide a swallowing	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 evaluation placed the resident at risk of unidentified swallowing problems and recurrent episodes of choking. Failure to care plan the interventions implemented did not ensure awareness and continuity of care by all staff members. Findings include: Review of the facility policy and procedure titled, "Dysphagia" occurred on 07/29/09. This policy and procedure, dated 01/09, stated, "PURPOSE, To provide guidelines to staff which promote adequate nutrition/hydration for residents with dysphagia. PROCEDURE, 1. Dietary/Nursing staff will observe for signs and symptoms of dysphagia when interacting with residents or when observing the meal service. Signs and symptoms of dysphagia are as follows: . . . coughing or choking when ingesting food or liquid . . . 2. Dietary/Nursing staff will notify the rehabilitation nurse and/or charge nurse if any of the above risk factors for dysphagia are present. 3. The rehabilitation nurse or charge nurse will contact the physician if risk factors do exist to request an (evaluate and treat) order by a dysphagia therapist (speech language pathologist or occupational therapist). . . . 9. Resident care plans will be updated by the center (either Nursing or Dietary) to include the diet order and swallowing interventions. . . ." Resident #1's medical record, reviewed on July 27-29, 2009, identified the facility admitted the resident in 12/06. Current diagnoses included history of strokes, dysphagia, and esophageal reflux. The current Minimum Data Set (MDS), dated 05/26/09, identified supervision of one	F 309	1. Resident #1 will have her individual needs met by informing her physician on the chewing and swallowing problems identified by the nursing staff on 7/29/09. The physician ordered a Speech Therapy consultation and it was completed on 7/29/09. The recommendation by the Speech Therapist was to have the resident complete a video fluoroscopy study. This was completed on 8/13/09. The results of the study indicated that the resident is able to continue her Level 2 dysphagia, mechanical soft with thin liquids diet. She was picked up for Speech Therapy services from 7/29/09 to 8/14/09. On 8/21/09 resident #1's care plan was updated to include a Level 2 dysphagia, mechanical soft with thin liquids diet and the resident and her responsible family members have been informed. The resident will be seen by the Registered Dietician on 8/29/09 to address elevated blood sugars, nutrition assessment and interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 person for eating, no chewing or swallowing problems, and no nutritional approaches. Resident #1's Interdisciplinary Notes identified the following: *05/15/09, 5:30 p.m., "Choked on hamburger @ [at] supper, able to clear on own." *06/28/09, 5:30 p.m., "CNA [Certified Nursing Assistant] reports past 3 noon meals [Resident #1] has choked on meat served, was able to cough meat up & [and] clear on own. CNA states [Resident #1] refused to leave DR [Dining Room] for nurse to assess. States she [is] fine, no negative effects noted, resps [respirations] dry & clear, states it's not unusual d/t [due to] her hx [history]." *07/10/09, 5:30 p.m., ". . . Had choking episode @ lunch causing her to have a small emesis. [No] residual effects from episode. . . ." Resident #1's Interdisciplinary Assessments and Summary Reviews, dated 07/15/09, stated "Dietary Note - Spoke [with] Resident [sic] about a concern of her having a few choking episodes during the dinner meals. We spoke on how she could have ground meat and she agreed. Diet changed today 07/15/09. Added to care plan." Resident #1's current care plan, dated 06/21/09, failed to identify a modification regarding ground meat. The resident's medical record failed to identify a request for a swallow evaluation. The facility staff identified Resident #1 choked on meal items five times. The facility staff made a change to ground meat. The facility staff failed to request a swallow evaluation which may identify a need for additional changes in food or drink consistencies, or a need for additional	F 309	The resident blood sugar levels are checked four times daily. The resident was seen by her doctor 8/6/09 and received new orders for increased insulin and to retest her Hgb A1C. Her care plan was updated on 8/21/09. Resident #3 will have her individual pain needs met by having a Pain Data Collection Tool completed on 8/26/09. Her physician will be contacted to address the residents' current pain with bathing. New orders will be processed and her care plan will be reviewed and revised. Employees #3 and #7 have been educated on the need to communicate resident pain to the charge nurse. 2. A list of residents with chewing and swallowing problems, elevated lab results that affect nutritional services and residents with expressed pain have the potential to be affected. (A list of residents with chewing and swallowing problems will be evaluated by the Registered Dietician or Speech Therapy.)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 interventions. The facility staff identified a need to care plan the change to ground meat, however the current care plan did not include this change. During interview, on 07/29/09 at 3:15 p.m., an administrative nursing staff member (#2) confirmed facility staff failed to request a swallow evaluation for Resident #1 and agreed they should have requested the evaluation. This staff member also reported the staff added the change to ground meat to the electronic care plan, but did not make a handwritten entry to the current care plan available to staff. Failure to request the swallow evaluation for Resident #1 placed the resident at risk for choking and illness related to choking. Failure to enter the change in diet consistency on the care plan available to all staff placed the resident at risk of receiving an incorrect diet and additional episodes of choking. 2. Based on record review, review of policy and procedure, review of professional reference, and staff interview, the facility staff failed to provide the care and services as ordered by the resident's physician regarding a dietary consult for 1 of 10 sampled residents (Resident #1). Failure to provide the dietary consult as requested may have resulted in Resident #1's continued elevated laboratory results and placed the resident at increased risk for skin breakdown and other complications related to elevated blood sugars. Findings include: Review of the facility policy and procedure titled "Physician's Orders" occurred on 07/29/09. This policy and procedure, dated 08/08, stated,	F 309	A list of residents with expressed pain have a pain data collection tool completed and identified pain will be addressed with the residents' physician and care plans will be reviewed and updated as needed. 3. A mandatory nursing and dietary meeting will be held on 8/26/09 to review the policy and procedure on dysphasia, processing physician orders and communicating resident pain. A new tracking form will be implemented titled "Dietary Consult Notification Form". When an order for a dietary consultation is received the nursing staff will complete the Dietician Consult Notification Form and route copies to Dietary Mgr, Unit Mgr and DNS. The Director of Dietary Services will notify the Registered Dietician of a physician ordered dietary consult. See Attachment A.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 "PURPOSE, To provide a procedure that facilitates the timely and accurate processing of physician's orders. INTRODUCTION, Physician's orders are a critical piece to providing quality care to residents. Accurate processing and handling of physician's orders is important. The Nursing Services and Health Information Management (HIM) departments each have responsibilities for processing physician's orders in a timely and accurate manner. . . . RECAPPING ORDERS, 51. Throughout a resident's stay at the center, physician's orders are being updated by new orders being prescribed and current orders being discontinued. At the same time, HIM is updating new orders and removing discontinued orders in the Physician's Orders module in Resident Services application. Therefore, it is important to recap and reprint the orders on a regular basis. 52. At the end of each month, the printed PHYSICIAN'S ORDERS (GSS #230C) in the medical record must be compared with the physician's orders in the Resident Services application. This is completed to ensure all orders received or discontinued throughout the month and documented in the medical record have been updated in Resident Services application before printing new MEDICATION AND TREATMENT ADMINISTRATION RECORDS (GSS #230C) for the next month. . . . DOCUMENTATION FLOW . . . 69. If orders are received for appointments . . . referrals . . . follow your center's procedure for noting, notifying appropriate parties including the resident's family/responsible party and scheduling of these orders. . . ." MayoClinic.com, reviewed on 07/29/09, regarding	F 309	4. An audit tool has been developed to track when physician orders are received for dietary consultation due to swallowing or chewing concerns, elevated lab results that affect nutritional services, and to track pain management for residents with expressed pain. The center will complete 5 random chart audits monthly for 3 months. The results of the audits will be reported to the QA/CQI committee for further recommendations. 1. The bath chair scale and wheelchair scale have been calibrated to ensure the accuracy of resident weights. Residents #2, #3, #8 and #9 will have his/her individual needs met by obtaining a new weight. If there is a weight gain or loss of 3 or more pounds the physician will be contacted and care plans updated as needed. 2. All residents have the potential to be affected. All residents will be re-weighed and weight variances of 3 or more pounds will be reported to the physician. New physician orders will be processed and care plans updated.	09/11/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6	F 309		

Hgb (Hemoglobin) A1C, stated "Specifically, the A1C test measures what percentage of your hemoglobin - a protein in red blood cells that carries oxygen - is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control. And if you have previously diagnosed diabetes, the higher the A1C level, the higher your risk of diabetes complications."

Resident #1's medical record, reviewed on July 27-29, 2009, identified the facility admitted the resident in 12/06. Current diagnoses included insulin dependent diabetes. The resident's current medications included scheduled and sliding scale insulin injections before meals and at bed time.

Resident #1's significant change Minimum Data Set (MDS), dated 01/13/09, identified one Stage II pressure ulcer and a history of resolved ulcers. The quarterly MDS, dated 02/16/09, identified a Stage II presssure ulcer. The quarterly MDSs, dated 02/18/09 and 03/04/09, identified a history of resolved ulcers.

Resident #1's Physician's Orders, dated 01/29/09, stated "Re [check] . . . HgbA1C in 3 months, Dietary Consult Re: [Regarding] [elevated] HgbA1C - limit sweets if able. . . ." The resident's laboratory results, dated 01/22/09, identified HgbA1C "7.2," "Reference Range, 4.0-6.0." The follow-up laboratory results, dated 03/19/09, identified HgbA1C "6.9."

Resident #1's Interdisciplinary Progress Notes, dated 01/29/09 at 1:45 p.m., stated "Seen by [physician]. Note new orders. Notified Dietary for need for Dietary Consult d/t [due to] [elevated] HgbA1C."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 Resident #1's current care plan, dated 06/21/09 and initiated 02/03/09, stated "Problems, Dx [Diagnosis] of diabetes . . . Goals . . . Lab values will be acceptable rage [sic] . . . Approaches . . . Monitor for s/s [signs/symptoms] of hypoglycemia [low blood sugar] . . . hyperglycemia [high blood sugar] . . . Lab as ordered . . ." and "Problems, Pot. [Potential] for skin breakdown r/t [related to] hx [history] of vascular ulcer L) [left] lat. [lateral] ft [foot] & [and] pressure ulcer L heel . . . At risk for impaired skin integr. [integrity] r/t diabetes . . . Is not always compliant with interventions. . . . Approaches . . . Involve/educate resident and/or family members . . ." Review of Resident #1's medical record failed to identify a dietary consult had been completed as requested by the physician. During interview, on 07/28/09 at 3:30 p.m., a dietary management staff member (#8) reported she was uncertain if Resident #1 received the dietary consult. During interview, on 07/29/09 at 12:00 noon, an administrative nursing staff member (#2) reported the dietary consult may have been filed in a "thinned" portion of the record. On 07/29/09, the staff member (#2) reported there was no record that the facility staff provided Resident #1 with the dietary consult requested by the physician. This staff member agreed the facility staff should have provided the consult. The facility identified Resident #1 was non-compliant with her diabetic diet restrictions, had a history of pressure ulcers, and was at risk of skin breakdown due to her history and diabetes. The resident's physician identified an elevated HgbA1C level and requested a dietary consult and to limit the resident's intake of sweets. Failure of facility staff to provide Resident	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 #1 with the dietary consult as requested by the physician on 01/29/09, may have contributed to the resident's continued elevated HgbA1C, and continued to place the resident at increased risk of skin breakdown and other complications related to elevated blood sugars. Failure to provide the consult as ordered limited the physician's ability to ensure Resident #1 received the appropriate treatment and services. 3. Based on observation, record review, and staff interview, facility staff failed to act upon a resident's voiced concerns of pain for 1 of 6 residents (Resident #3) identified on the facility roster as experiencing pain/comfort issues. Failure of staff to act on resident's stated concerns of pain has the potential for the resident to experience increased levels of pain. Findings include: Observation of cares on 07/28/09 at 9:43 a.m. for Resident #3, showed two certified nursing assistants (CNAs) (#3 and #7) assisting the resident out of bed to go for a whirlpool bath. While still lying in bed, Resident #3 commented about asking a nurse for some Tylenol earlier in the morning for pain in her left arm/shoulder and stated the nurse had not brought it yet. As the CNAs (#3 and #7) transferred Resident #3 to the bath chair using a full body lift, the resident indicated she felt pain in her left arm/shoulder. As Resident #3 sat in the bath chair, she stated her arm/shoulder hurt when sitting in the bath chair as there is no support for her left arm. The CNA (#7) stated to Resident #3 that she knows the resident's arm has no place to rest and that it has caused her discomfort while bathing. At no time during the observation did one of the CNAs (#3 or	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

#7) communicate with the nurse to have Tylenol administered to Resident #3 or to see if the nurse gave Resident #3 the earlier requested Tylenol.

- Resident #3's medical record, reviewed July 27-29, 2009, identified the facility admitted the resident in July 2008. Current diagnoses include depression, mild to moderate pain and osteoporosis. An annual MDS, dated 07/19/09, identified Resident #3 has short and long term memory problems, is totally dependent with help of two or more staff members for transfers and bathing, and has moderate pain less than daily in a joint other than her hip.

The current plan of care for Resident #3 included the following:

"Problem/Needs/Concerns: Potential for alteration in comfort D/T [due to] DX [diagnosis] of osteoporosis and medical complications.

Long/Short term goals: Will express relief form pain medication through [sic].

Estimated resolve date: 04/20/09.

Plans and Approaches: Medicate as ordered. Monitor for response to medication and notify physician as needed. Provide appropriate diversional activity if having increased discomfort. Offer warm blankets as needed to affected areas. Provide reassurance that various options are available."

"The Pain Data Collection Tool" completed for Resident #3 on 01/20/09 identified the following:

". . . 5. Quality: Use resident's own words that describe pain. 'Actually just hurts if shoulder hurts first thing in the AM [morning] I get my fingers going'

6. Duration and when it occurs (frequency). 'If not repositioned right.'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 7. What relieves the pain? 'Moving - medication.' 8. What increases the pain? 'Poor positioning'. . . " The physician order sheet showed Resident #3 had an order for Tylenol 650 milligrams as needed up to four times a day. Review of the medication administration record at 4:40 p.m., on 07/28/09 identified Resident #3 did not receive a dose of Tylenol as she had requested earlier in the morning. Failure of the CNAs (#3 and #7) to communicate to the nurse Resident #3's expressed complaints of pain to her left arm/shoulder, caused her increased discomfort during a care where the CNA (#7) identified to the resident she knew Resident #3 would be uncomfortable. Though the CNA (#7) acknowledged Resident #3's discomfort, the CNAs (#3 and #7) failed to report Resident #3's complaint of pain to the nurse. During an interview with an administrative nurse (#2), on 07/29/09 at 3 p.m., the nurse (#2) agreed CNAs need to communicate resident's reports of pain to the nurse.	F 309	3. A mandatory nurses meeting will be held on 8/26/09. Nursing staff will receive training on the policy and procedures titled, "Weight Monitoring" and "Weight and Height." 4. An audit tool will be developed to monitor weight variances of 3 or more pounds and the calibration of the two scales. The audit will be completed monthly for 3 months by the DNS or DDS. The results of the audits will be reported to the QA/CQI committee for further recommendations.	09/11/2009
F 325 SS=E	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	1. Resident #11's individual needs have been met by having an accurate Controlled Substance Record for Oxycodone ER. Nurse #1 received education on the procedure for counting controlled substances on 8/12/09. The Consultant Pharmacist and Medical Director were informed of the inaccurate drug count for resident #11 on 8/13/09. 2. All residents receiving narcotics have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 11	F 325		

This REQUIREMENT is not met as evidenced by:
Based on record review, review of policy and procedure, and staff interview, the facility failed to ensure acceptable nutritional parameters regarding accurately documented weights for 4 of 6 sampled residents (Resident #2, #3, #8, and #9) identified as being at nutritional risk by the facility. Failure to ensure the accuracy of resident weights and to re-weigh the residents when errors are suspected (as much as 34.6 pounds for Resident #8) limited the facility's ability to accurately determine the residents' weights, the significance of weight loss (if any), the need for interventions, and the effectiveness of any interventions implemented.

Findings include:

Review of the facility's policy "Weight and Height" occurred on 07/29/09. This policy, dated 01/09, stated,
"PURPOSE
To accurately measure weight and height
To monitor weight loss or gain in a resident . . .
Residents at nutritional risk will be weighed weekly. . . .
The registered dietitian (RD) or director of dietary services (DDS) will monitor weights monthly for changes. . . .

WEIGHT PROCEDURE . . .
5. Weigh resident and record weight. . . .
7. If weight varies by more than five pounds, re-weigh resident within 24 hours and document, Report weight to licensed nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12	F 325		

8. Compare weight with previous weights, note and report any five-pound changes to the licensed nurse. If the weight varies by more than five pounds, re-weigh resident within 24 hours and document. . . ."

- Resident #8's medical record, reviewed on July 29, 2009, identified the facility admitted the resident in October 2003. Current diagnoses included Parkinson's, anemia, depression, and esophageal reflux. A quarterly Minimum Data Set (MDS), dated 05/06/09, identified Resident #8 eats with supervision and limited assistance of one staff member, has chewing problems, received a mechanically altered diet, and weighed 81 pounds. The current care plan identified an approach to weigh weekly with bath and to reweigh if gain or loss of three pounds or more. A dietary consult, dated 06/12/09, showed Resident #8 consumed 25-50% of meals, but would not accept changes to her diet plan. The consultant recommended to continue with the current plan and continue to monitor.

Review of the resident's Weight Record, on 07/29/09, identified the following weights and failed to identify re-weighs.

*02/23/09 - 82.5 pounds
*03/02/09 - 117.1 pounds (a 34.6 pound gain)
*03/05/09 - 86.0 pounds (a 31.1 pound loss)

*03/16/09 - 86.0 pounds
*03/23/09 - 82.0 pounds (a 4 pound loss)

*04/06/09 - 81.5 pounds
*04/13/09 - 84.5 pounds (a 3 pound gain)
*04/20/09 - 80.5 pounds (a 4 pound loss)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 13 *07/20/09 - 78.5 pounds *07/27/09 - 82.0 pounds (a 3.5 pound gain) The facility failed to accurately monitor Resident #8's weight when they did not re-weigh the resident when her weight fluctuated by three or more pounds as identified in the above examples. - Resident #3's medical record, reviewed July 27-29, 2009, identified the facility admitted the resident in July 2008. Current diagnoses included depression, unspecified vitamin disorder, anemia, chronic recurrent decubitus ulcers, diabetes, and acute renal failure. An annual MDS, dated 07/01/09, identified a weight of 199 pounds and failed to identify Resident #3 as on a planned weight loss program. The nutritional resident assessment protocol, dated 07/01/09, identified Resident #3 is on a weight reduction diet. Resident #3 received a nutritional consult on 07/17/09, in which the dietician discussed the resident's desire to maintain or gradually lose weight. Review of the resident's Weight Record, on 07/29/09, identified the following weights and failed to identify re-weighs. *09/30/28 - 194.0 pounds *10/07/08 - 189.0 pounds (a 5 pound loss) *10/14/08 - 198.0 pounds (a 9 pound gain) *01/20/09 - 198.0 pounds *01/27/09 - 183.0 pounds (a 15 pound loss) *02/06/09 - 185.6 pounds *02/10/09 - 197.0 pounds (an 11.4 pound gain) *02/24/09 - 195.0 pounds *03/04/09 - 205.0 pounds (a 10 pound gain)	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 14	F 325		

*03/10/09 - 205.0 pounds
*03/17/09 - 193.0 pounds (a 12 pound loss)

*05/19/09 - 198.0 pounds
*05/26/09 - 186.5 pounds (an 11.5 pound loss)
*06/02/09 - 200.0 pounds (a 14. 5 pound gain)

Failure to ensure the accuracy of a resident's weight and failure to re-weigh a resident, limited the facility's ability to evaluate the effectiveness of interventions implemented.

- Resident #9's medical record, reviewed on July 29, 2009, identified the facility admitted the resident in January 2004. Current diagnoses included dementia, diabetes, Parkinson's, constipation, diverticulosis, and depression. The quarterly MDS, dated 05/19/09, identified Resident #9 eats independently after set up, has chewing problems, received a mechanically altered diet, and weighed 189 pounds. The current care plan identified an approach to weigh weekly with bath and to re-weigh if gain or loss of three pounds or more.

*09/10/08 - 196.4 pounds
*10/01/08 - 188.5 pounds (a 7.9 pound loss)

*10/22/08 - 192.8 pounds
*10/29/08 - 189.0 pounds (a 3.8 pound loss)
*11/05/08 - 192.0 pounds (a 3 pound gain)
*11/11/08 - 189.0 pounds (a 3 pound loss)

*12/09/08 - 188.0 pounds
*12/17/08 - 192.0 pounds (a 4 pound gain)
*01/02/09 - 188.3 pounds (a 3.7 pound loss)

*03/31/09 - 187.5 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 15 *04/07/09 - 194.5 pounds (a 7 pound gain) *04/14/09 - 190.0 pounds (a 4.5 pound loss) *05/12/09 - 189.0 pounds *05/19/09 - 192.5 pounds (a 3.5 pound gain) *05/26/09 - 189.5 pounds (a 3 pound loss) *06/02/09 - 186.0 pounds (a 3.5 pound loss) *07/21/09 - 188.0 pounds *07/28/09 - 176.0 pounds (a 12 pound loss) The facility failed to accurately monitor Resident #9's weight when they did not re-weigh the resident when her weight fluctuated by three or more pounds as identified in the above examples. - Resident #2's medical record, reviewed on July 27-29, 2009, identified the facility admitted the resident in 01/08. Current diagnoses included dysphagia, history of pressure ulcers, and kidney disease. The current Minimum Data Set (MDS), dated 07/18/09, identified extensive assistance of one person for eating, swallowing problems, a mechanically altered diet, and a weight of 179 pounds. The resident's Nursing Annual Review documentation by nursing and dietary staff, dated 05/11/09, identified concerns of weight loss. Review of the resident's Weight Record, on 07/29/09, identified the following weights and failed to identify re-weighs. *11/07/08 - 204.0 pounds *12/03/08 - 197.0 pounds (a 7 pound loss) *12/11/08 - 203.0 pounds (a 6 pound gain) *05/25/09 -186.0 pounds	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 16 *05/31/09 - 180.5 pounds (a 5.5 pound loss) During interview, on 07/29/09 at 1:30 p.m., an administrative nursing staff member (#2) stated it was her expectation facility staff would re-weigh residents and report weight changes of more than three pounds in one week. Failure to ensure the accuracy of resident weights and failure to re-weigh residents with a weight change limited the facility's ability to evaluate the effectiveness of interventions implemented for nutrition risk and limited the staff's ability to identify residents at nutrition risk. This placed all the facility residents at risk of unidentified weight loss.	F 325	A list of residents currently receiving schedule II-V controlled substances will have their narcotic sheets reviewed to ensure proper counting of controlled substances. 3. A mandatory Nurses meeting will be held on 8/26/09. Nurses will be re-educated on the procedure for Controlled Substances. 4. An audit will be developed to monitor accurate narcotic counts. The audit will be completed 2 times a week for 2 weeks, than monthly for 2 months by the DNS or her designee . The results of the audit will be reported to the QA/CQI committee for further recommendations. 9/11/09 Phone Call R. Shiffler, DON 9/02/09 LB 1. Residents that receive medication identified as the "4 medications in the medication room and 11 medications in the medication cart", which were the medications that lacked expiration dates, were reviewed by the pharmacist to ensure medications were not expired, but they were not labeled correctly with an expiration date. The identified medications were received	
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional literature, the facility failed to ensure accurate monitoring for 1 of 3 resident (Resident #11) narcotic records. Failure to keep accurate records of controlled substances has the potential for the resident's medication to be misappropriated and/or not available for the resident's use. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, pages 832-833 stated: "Another aspect of nursing practice governed by law is the use of controlled substances. . . . controlled substances are kept in a locked drawer, cupboard, medication cart, or computer-controlled dispensing system. Agencies may have special inventory forms for recording the use of controlled substances. . . . Before removing a controlled substance, the nurse verifies the number actually available with the number indicated on the narcotic or controlled substance inventory record. If the number is not the same, the nurse must investigate and correct the discrepancy before proceeding. . . . In most agencies, counts of controlled substances are taken at the end of each shift. The count should tally with the total at the end of the last shift minus the number used. . . " A tour of the medication storage areas took place on 07/28/09 at 2:20 p.m. with a licensed nurse (#1). Observation identified the medication cart equipped with a locked box in which staff stored	F 425	from two different pharmacies, Thrifty White Drug and North Port Pharmacy. Each pharmacy was contacted on 8/12/09 to ensure medications were not expired. New labels have been ordered on 8/24/09 for the identified medications. 2. All residents that receive medications from Thrifty White Drug and North Port Pharmacy have the potential to be affected. A list of residents that order medications from Thrifty White Drug and North Port Pharmacy will be generated to check for expiration dates on the labels. 3. A mandatory meeting for licensed nursing staff will be held on 8/26/09 to provide education on "The ASCP Guidelines on prepackaging of medications". The DNS will contact the seven pharmacies that serve GSS Arthur and discuss the need for an expiration date to be included on the label. Each pharmacy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 18 controlled substances. The nurse (#1) removed the "Individual Resident's Narcotic Record" sheets from the drawer. Three sheets, randomly chosen for review, showed the facility failed to keep an accurate count of Resident #11's Oxycodone ER (extended release), an opioid analgesic. The "Individual Resident's Narcotic Record" identified a count of 41. A count performed with the licensed nurse (#1) identified 40 tablets in the bubble pack. A second count verified 40 tablets. The nurse (#1) reviewed the "Individual Resident's Narcotic Record" and identified the nurse administering the 8 p.m. on 07/27/09 failed to document the administration of the medication on the sheet. The "Individual Resident's Narcotic Record" for Resident #11 revealed staff counted the Oxycodone ER at the change of shift on 07/28/09 at 6 a.m. Facility staff failed to identify that the number of tablets in the medication cart did not match the number on the "Individual Resident's Narcotic Record." During interview with an administrative nurse (#2), on 07/29/09 at 3 p.m., this nurse indicated staff need to keep accurate "Individual Resident's Narcotic Records" and perform accurate counts at change of shift.	F 425		
F 431 SS=B	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 19 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of professional literature, the facility failed to assure the labels of medications included the expiration dates in accordance with professional standards for long term care facilities. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding labeling of medications and biologicals	F 431	will also be mailed a copy of these guidelines. 4. The center will complete an audit titled "Medication Order Check" for medications received from Thrifty White Drug an North Port Pharmacy 2 times a week for 2 weeks, and then monthly for 2 months to ensure compliance in this area. The DNS or her designee are responsible for the completion of this audit. The results of the audits will be reported to the QA/CQI committee for further recommendations.	09/11/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 20 which requires facility compliance with currently accepted labeling requirements. The pharmacies are responsible for the actual labeling. Labeling of medications and biologicals dispensed by the pharmacy must be consistent with applicable federal and State requirements and currently accepted pharmaceutical principles and practices. Although medication delivery systems may vary, the medication label at a minimum includes the medication name (generic and/or brand) and strength, the expiration date when applicable. "Guidelines on prepackaging of medications" approved by the ASCP (American Society of Consultant Pharmacists) Board of Directors, November 10,1998. The guideline stated, "Preamble: Certain precautions must be taken if the quality of prepackaged medication is to be maintained. . . . The desired components are as follows: . . . 5. Beyond-use date (expiration date) . . ." A tour of the medication storage area took place on 07/28/09 at 2:20 p.m. with a licensed nurse (#1). Observation of a storage cabinet in the medication room showed four medications which lacked labels with expiration dates. Observation of medications in the medication cart revealed eleven medications which lacked expiration dates. The licensed nurse (#1) identified the nursing staff checking the medications at the end of the month or the nurse who received these medications in the mail should have noted the lack of expiration dates. During interview with an administrative nursing	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 21 staff member (#2), on 07/29/09 at 3:00 p.m., this staff member agreed pharmacy labels should include an expiration date.	F 431		